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ILLINOIS

United States Senate

WASHINGTON, DC 20510

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AGING

July 8, 2016

The Honorable Michael Missal
Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Mr. Missal,

Please find enclosed the Illinois Guardianship and Advocacy Commission's recent investigations into ongoing rights violations committed against Illinois veterans with disabilities at the Edward Hines Jr. and Jesse Brown Veterans Affairs Hospitals.

The Commission is particularly concerned with the forced administration of psychotropic medication, sometimes with VA police presence, without adequate cause to a veteran's mental health needs and the issuance of criminal citations for a veteran exhibiting mental health related behavioral symptoms. As the Commission explains it, the VA Hospitals use the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107) to involuntarily commit veterans, however, they fail to uphold the same Code's rights protections for these veterans.

The Guardianship and Advocacy Commission was created to protect the rights and promote the welfare of Illinois disabled citizens. I am confident you share my concerns over the violations the Commission has investigated and ask that you open an investigation. Specifically, please focus on the following questions:

1. The report details a complaint where VA police were present during the administration of medication "to hold the patient (sic) down if he refused." What is the VA policy regarding the involvement of VA police officers in the administration of treatments with patients?

2. As a federal agency, what is the standard for VA facilities to follow state laws that govern how patients in mental health units must be treated and how medications are administered? This report suggests that violations of Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107) occurred when staff administered forced psychiatric medication to veterans. Were the rights of the Illinois veterans mentioned in this report violated while in the care of the VA hospitals? What Illinois and federal laws, as well as VA policies, were overstepped or disobeyed by the VA health care professionals or the VA police officers during the incidents described in the report?

3. This report indicates that staff in the Behavioral Health Unit at Hines VA Hospital "have stated that forced medications are given on an emergency basis at the first sign of agitation." The report states that upon investigation in Authority case #14-030-9023, the veteran did not meet the standard for dangerousness before forced medication was administered. What is the VA policy for administrating emergency medication without

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veteran consent? What assessments are employed to determine if/when a veteran is exhibiting dangerous or self-harming behavior requiring emergency medical intervention? Is there a VA standard for such assessments? What training is VA staff provided to identify these behaviors?

4. This report includes testimony from a VA physician who states "I wouldn't use emergency medications at all. But these are trained killers." Is this standard VA policy when interacting with veterans with mental illness?

5. This report states that upon investigation in Authority case #15-030-9003, the Jesse Brown VA Hospital inappropriately issued a criminal citation for a veteran who exhibited behaviors related to his documented mental illness. This report indicates this is a direct violation of protection guaranteed by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 4/1 et eq.) Were the rights of the Illinois veterans mentioned in the report violated while in the care of the VA hospitals? What Illinois laws or policies were overstepped or disobeyed by the VA health care professionals or the VA police officers during the incidents described in the report?

6. The Commission states that "attempts to resolve the violations at these hospitals have either been unsuccessful or ignored." Additionally, this report states that "even after repeated requests the VA has failed to respond to these substantiated findings of rights violations for Illinois veterans with disabilities," and that the two above mentioned cases were closed and published without any VA response. Why was there no response by the VA to these reports? What action has the leadership at Hines and Jesse Brown VA hospitals taken to address the Commission's concerns and recommendations? Does the VA have a policy in place requiring response to state investigations based on violations against veterans in the VA's care?

7. There is a reported practice of issuing criminal citations to in-patient veterans with mental illness. This report indicates that the Commission's Legal Advocacy Service Program has represented veterans at both Hines and Jesse Brown VA in involuntary commitment and court ordered medication hearings, one of which the veteran could not attend his hearing due to his in-patient status in the VA Behavioral Health Unit, but it took painstaking steps by the legal team to get the citation dropped so the veteran patient would not be held in contempt. What are the VA policies governing VA police issuing criminal citations to veterans on the premises of VA hospitals, and most importantly, those veterans who are receiving in-patient treatment?

I am concerned that these practices may be widespread and only thanks to the Illinois Guardianship and Advocacy Commission these violations were uncovered. Veterans with mental health problems should not be treated with less respect or without protections of their rights. Finally, I request that the VA establish a working relationship with state agencies like the Commission who provide important services to our less fortunate and disabled veterans. The wellbeing and humane treatment of veterans in need of mental health care is of vital importance. Federal and state agencies should be working together in the best interest of our nation's heroes.

I look forward to receiving timely updates on your investigation and learning of your findings and recommendations to protect the rights of veterans who are seeking or in need of treatment at a Behavior Health Unit at Hines and Jesse Brown VA Hospitals.

I appreciate you opening an investigation into these allegations.

Sincerely,

Mark Kirk
United States Senator

Enclosures